SWINOMISH HEALTH CLINIC
P.O. BOX 683-17400 RESERVATION
LA CONNER, WA 98257
(360) 466-3167

Authorization to Release Confidential Information to Family Members

Name of patient: _____ Date of birth: _____ Social Security #: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this specific service provider, therapist, case manager, or _____, to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an × in the boxes below, and any items not to be released have a line drawn through them:

❑ Name of therapist ❑ Name of case manager ❑ Name(s) of treatment program(s)

❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments ❑ Progress notes

❑ Compliance with treatment ❑ Discharge plans ❑ Treatment summary

❑ Psychological evaluation ❑ Medications ❑ Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name of person	Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire on ❑ 1 year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances: _____

Signature of client	Printed name	Date

Signature of parent/guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness	Printed name	Date

Signature of witness (a second witness is needed if person is unable to give oral consent)	Printed name	Relationship	Date

❑ Copy for patient or parent/guardian ❑ Copy for provider/therapist/case manager ❑ Copy for family member

FORM 53. Authorization to release confidential information to family members. Adapted from Marsh (1995).